Diagnosis and Treatment of Prostatitis

TO THE EDITOR: Articles that review prostatitis for nonurologists never seem to give clinicians an idea of the relative frequency of the various types. Hence, I make a few comments to supplement Dr Shortliffe's presentation in the October issue.[1]

Acute bacterial prostatitis is a very *un*common disease. I have been impressed that the patients may simply have a flu-like syndrome of headache, myalgia and fever for 24 to 48 hours *before* any urinary tract symptoms ever develop. Having a high index of suspicion and doing an analysis of urine will yield the diagnosis. Chronic bacterial prostatitis is likewise an uncommon entity, and the treatment is as Dr Shortliffe outlined.

Abacterial prostatitis is by far the most common entity. It seems to be precipitated in many instances by stress in the broadest sense of the term (fatigue, another illness or traveling, for example). Why this inflammatory problem seems to respond so well to trimethoprim-sulfamethoxazole I am not sure. Perhaps the newer once-a-day anti-inflammatory drugs (such as Indocin SR) would be a better way to initiate therapy. Crucial to the patient's getting better is an explanation that this is a benign problem, albeit a nuisance, and that it may come and go. Caffeine (a prostatic irritant) may exacerbate symptoms and sitz baths will alleviate mild to moderate discomfort.

Prostatodynia is a poor term. Either the patient has prostatitis (even if massage did not happen to express pus from the involved portion of the gland) or he does not—and another term should be used. Regardless, inflammation *is* present or the patient would not have symptoms, and I concur with Dr Shortliffe that anti-inflammatory drugs, muscle relaxants and sitz baths may all be useful.

GREGORY E. POLITO, MD
Whittier, California

REFERENCE

1. Shortliffe LMD: Prostatitis: Still a diagnostic and therapeutic dilemma (Topics in Primary Care Medicine). West J Med 1983 Oct; 139: 542-544

Community Hospital CME—Its Proper Place

TO THE EDITOR: In the September 23 edition of *JAMA* is the annual summary of medical education in the United States, 1982-1983. But again, as has been the case previously, the space and interest devoted to community-hospital-based continuing medical education (CME) is piteously brief, especially when compared with the attention lavished on other aspects of medical education and training. Moreover, when one considers the magnitude of desired and required continuing postgraduate training as reflected in the extensive time and effort devoted to credentialing new medical staff applicants, proctoring them subsequently and then recredentialing them periodically for maintenance of medical-surgical skills, the problems of hospital-based CME activities come into even sharper focus.

Additionally, if anybody is interested in it (and we really are or ought to be), the expense of university-sponsored CME programs to attending private practitioners is very considerable indeed. For an average internist, the cost merely begins with a $350 fee for a typical two-day conference. Add to that the cost of travel and lodging plus loss of income, one is conservatively looking at expenses of $1,600 to $1,900, some of which might well be replaced by sophisticated community-hospital-centered CME activities.

The treatment of this kind of postgraduate study, although substantially better than four to five years ago, is symptomatic of our relative neglect of community hospital CME. The attention and assistance dedicated to it at higher organizational levels of state medical associations and the American Medical Association are insufficient. Some serious effort on the part of organized medicine is due now, without the delay of another year, for the purpose of enhancing the quality and availability of community-hospital CME activities.

ALVIN LEE BLOCK, MD
Medical Coordinator
Queen of the Valley Hospital
Napa, California